

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00196359.</p> <p>Complaint IN00196359 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F224.</p> <p>Survey dates: March 29, 30 and 31, 2016</p> <p>Facility number: 000274 Provider number: 155810 AIM number: 100271660</p> <p>Census bed type: SNF/NF: 72 Total: 72</p> <p>Census payor type: Medicare: 1 Medicaid: 70 Other: 1 Total: 72</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>			F 0000	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law. Plan of Compliance is effective: April 18, 2016 Vernon Manor requests changes in two deficiencies alleged in the 2567 for the survey completed April 1, 2016: we request a reduction in the scope and severity of finding F157 and the removal of finding F224 Mistreatment, Neglected Misappropriation. All findings associated with these tags relate to the same individual, Resident B.</p>		
F 0157	483.10(b)(11)						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
SS=J Bldg. 00	<p>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified in a timely manner of a resident's increased body temperature (Resident B).</p>			F 0157	<p>F157J Physician Notification Corrective action for affected residents: Resident B discharged Identification of others at risk: Review of nurse progress notes for changes of condition and physician</p>		04/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>The immediate jeopardy began on 3/13/16 when the facility failed to notify the physician of an elevated temperature of 103.9 degrees Fahrenheit (F). The Executive Director, Director of Nursing and Regional Director were notified of the immediate jeopardy on 3/31/16 at 12:00 p.m. The Immediate Jeopardy was removed 4/1/16 when the facility developed and implemented a systematic plan of correction.</p> <p>Findings include:</p> <p>During record review on 3/29/16 at 9:55 a.m., the clinical record indicated Resident B was admitted to the facility on 10/27/12. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, profound intellectual disability, anxiety, shaken infant syndrome and gastrostomy tube. The Minimum Data Set (MDS) quarterly assessment dated 1/7/16, indicated Resident B was unable to complete the Brief Interview Mental Status (BIMS). Resident B was severely cognitively impaired.</p> <p>During review of a progress note dated 3/13/16 at 6:45 p.m., RN #1 noted a fever. The note indicated the nurse gave 600 milligrams of ibuprofen. On 3/14/16 at 6:00 a.m., LPN #2 indicated the</p>				<p>notification for the past two weeks reveal no areas of concerns.</p> <p>Measures to ensure this deficit practice does not recur: The nursing staff were re-educated on regulation F157 regarding change of condition including notification of physician; and policy & procedures regarding notifications. Monitoring of corrective action: Residents with significant changes in condition will be audited 5 times weekly for 6 months, then 2 times weekly for 6 months. Results of this monitoring will be reported through the QA Committee for further recommendations. Vernon Manor requests changes in two deficiencies alleged in the 2567 for the survey completed April 1, 2016: we request a reduction in the scope and severity of finding F157 and the removal of finding F224 Mistreatment, Neglected Misappropriation. All findings associated with these tags relate to the same individual, Resident B. Please see attached IDR request</p> <p>Resident B was admitted Vernon Manor on 10/27/2012. His diagnoses included spastic quadriplegic cerebral palsy, profound intellectual disability, anxiety, shaken infant syndrome, gastrostomy tube, autistic</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>resident was resting in bed, moaning. He had an elevated temperature and ibuprofen was given.</p> <p>Review of the vital signs record, on 3/13/16 at 6:04 p.m., Resident B had an elevated temperature of 103.9 degrees Fahrenheit (F).</p> <p>A progress note dated 3/14/16 at 11:57 a.m., LPN #2 indicated an elevated temperature and "tylenol" given.</p> <p>A progress note on 3/14/16 at 4:16 p.m., LPN #2 indicated an elevated temperature of 100 degrees F.</p> <p>A progress note dated 3/14/16 at 5:03 p.m., indicated LPN #2 notified "Md of increase temps." The physician responded to monitor the resident at this time.</p> <p>A progress note dated 3/14/16 at 7:00 p.m., RN #1 indicated an elevated temperature of 102.5 F. Ibuprofen was given. RN #1 noted the abdomen to be "slightly firm and tender to palpation, resident is expelling gas."</p> <p>A note dated 3/14/16 at 8:02 p.m., RN #1 indicated an elevated temperature of 100.2 F, but indicated the resident continued to have abdominal tenderness</p>				<p>disorder and severe cognition impairment.</p> <p>On the evening of Sunday, March 13, 2016, the attending nurse identified that Resident B felt warm and had a temperature of 103.9. After administering ibuprofen, she attempted to contact the attending physician by phone. The physician did not answer. The physician does not have voicemail set up and the nurse was unable to leave a message. She subsequently completed a SBAR (Subject Background Assessment Request) and faxed it to the physician (Exhibit A.) The facility received confirmation that the fax was received (Exhibit B.). Vernon Manor received no response.</p> <p>The next morning, at 9:57 a.m. a Vernon Manor nurse notified the physician's nurse that Resident B had elevated temperatures. Approximately two hours later Vernon Manor received an order to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>with palpation.</p> <p>A progress note dated 3/15/16 at 12:52 p.m., indicated resident was afebrile (temperature not elevated) with hypoactive bowel sounds and discomfort with palpation.</p> <p>A progress note dated 3/15/16 at 1:29 p.m., indicated the physician was notified of the residents vital signs and abdominal tenderness. No specific numbers were indicated.</p> <p>A progress note dated 3/15/16 at 2:49 p.m., RN #4 indicated a new order for Resident B to have the following: "chest x-ray, Complete Blood Count (CBC), Basic Metabolic Panel (BMP) and 2 sets of blood cultures done 15 minutes apart." The order indicated the chest x-ray would be done "tonight."</p> <p>A progress note dated 3/15/16 at 5:00 p.m., LPN #3 indicated "may have labs drawn 3/16/16 in the AM per [name of physician]."</p> <p>A progress note dated 3/16/16 at 1:58 a.m., LPN #5 indicated the breath sounds had rhonchi [low-pitched] breath sounds.</p> <p>A progress note dated 3/16/16 at 8:30 a.m., indicated "CBC, BMP and blood</p>		<p>monitor the resident (Exhibit C and D.) Neither a discontinuation of an existing form of treatment nor a commencement of a new form of treatment was ordered at that time.</p> <p>The principal focus of tag F 157 seems to be the performance of the staff after Resident B was noted as having a high temperature on March 13. Vernon Manor contends that it used reasonable efforts to advise and consult with Resident B's physician concerning the change in Resident B's temperature on March 13. Shortly after the increased temperature was noted, a call was placed to the physician. The physician did not answer. The physician acknowledges that she does not have voice mail set up. Nursing measures were implemented, including monitoring of vital signs each shift. As the preferred method of contacting the physician had not worked,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>cultures drawn per hosp lab from left hand this am. 15 minutes later 2nd set of blood cultures drawn from right hand."</p> <p>A note dated 3/16/16 at 12:27 p.m., indicated the Director of Nursing (DON) informed the physician of the chest x-ray results. The x-ray indicated a right perihilar infiltrate. The physician was also notified of the CBC and BMP results.</p> <p>A new order was received on 3/16/16 at 3:48 p.m. The order indicated to start Bactrim DS [antibiotic] 800mg/160mg, 1 tablet twice daily for 10 days and Zithromax [antibiotic] 500 mg daily for 10 days. The family was notified of the order.</p> <p>A progress note dated 3/17/16 at 2:06 a.m., LPN #5 indicated "Dr. [name of physician] notified of culture results." Review of laboratory blood culture results, dated 3/16/16, indicated a preliminary result of Streptococcus A. Interview with LPN #5 indicated she had faxed the report and not actually spoken to the doctor.</p> <p>A progress note dated 3/17/16 at 7:30 a.m., indicated the DON spoke to the physician about the positive blood culture, related to isolation precautions.</p>			<p>the nurse followed up with a fax to the physician advising of the change. The surveyor's criticism of the Vernon Manor nurse for not doing additional follow-up is unwarranted, as Vernon Manor received verification that the fax had been received.</p> <p>We also note inconsistencies in the survey. Page 15 includes statement from the physician that she received no updates on Resident B's condition on March 16. In fact, the physician's nurse was present in Vernon Manor on that day and observed Resident B. In addition, it is noted on page 5 that the DON informed the physician of the CBC and BMP results.</p> <p>In addition, communication with the physician regarding Resident B's temperatures and general status continued on March 15 at 1:29 p.m. (Exhibit E), March 15 at 2:49 p.m. (Exhibit F), March 15 at 5:00 p.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>A note on 3/17/16 at 8:40 a.m., indicated Resident B was observed between the floor and the bed, "crawling as per normal...." Resident B was observed to have the following abrasions: 4.5 cm x 5.0 cm to the right temple and a 2 cm x 2 cm to right ankle. Emesis was on his clothing and bedding. LPN #3 indicated "BrSo [breath sounds] are clear and BoSo [bowel sounds] active in all four quadrants".</p> <p>At 9:00 a.m., the physician was notified in person of the resident's vital signs and went to assess the resident. The order was given to send the resident to the local hospital. Resident B was transported to the hospital on 3/17/16 at 9:15 a.m.</p> <p>Review of an Event Report, dated 3/13/16 at 6:45 p.m., LPN #5 noted a temperature of 103.8 degrees F. The report indicated the event started on 3/13/16 at 6:03 p.m. The report indicated "Physician Notified: Yes Date/Time: 3/14/16 at 12:51 AM".</p> <p>During an interview on 3/31/16 at 9:20 a.m., the physician indicated she was not notified of an elevated temperature of 103.9. She indicated she was notified of a temperature on Monday from her nurse. The physician's nurse, LPN #6, indicated</p>			<p>(Exhibit G), March 16 at 12:27 p.m. (Exhibit H), March 16 at 3:48 p.m. (Exhibit I), March 17 at 2:06 a.m. (Exhibit J), March 17 at 5:10 a.m. (Exhibit K), March 17 at 7:30 a.m. (Exhibit L) and March 17 at 9:00 a.m. (Exhibit M). Resident B was evaluated by the physician on the morning of March 17 and subsequently transferred to a hospital.</p> <p>Attached as Exhibit N is a chronology showing communications and significant events involving Resident B over the period in question. The events identified in 2567 are shaded. Exhibit N shows that there were more communications between Vernon Manors' nursing staff, the physician, and the physician's nurse than reflected in the 2567. Several of these additional communications are set forth in Exhibit O.</p> <p>Tag F 224 asserts that Vernon Manor violated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>she had received a text message from LPN #2 on 3/14/16 at 9:57 a.m., indicating Resident B had a temperature in the 100 range and had vomited his narcotic medication. The physician indicated she was informed on Tuesday (3/15/16) the resident had abdominal tenderness, but with positive bowel sounds. She received no update on Wednesday(3/16/16). She indicated on Thursday (3/17/16), she had received a fax at 2:35 a.m., indicating a positive blood culture. The report only indicated the resident had Gram Positive Cocci (GPC). She indicated she had spoken to the DON prior to her 8:00 a.m. meeting. She indicated the DON was concerned about the blood culture containing streptococcus pyogenes (strep A). The physician indicated she was not aware of the recent culture results. She indicated she immediately contacted her nurse and gave an order for Penicillin 2 million units intravenously every 4 hours with no stop date. She indicated she gave that order around 7:55 a.m., just before her meeting started.</p> <p>During an interview on 3/31/16 at 9:20 a.m., LPN #6 indicated she wrote the order on a sticky note and gave to LPN #3. The note indicated an order for Penicillin 2 million units intravenously every 4 hours with no stop date</p>		<p>regulation 42 CFR 483.13(c), and the same observations used to support F 157 are used to support F 224. We make the same responses to F 224 as to F 157.</p> <p>We furthermore dispute the conclusion on page 11 that <i>"...the facility failed to ensure the physician was notified in a timely manner of a resident's increased body temperature. This failure resulted in a delay in medical care, hospitalization and death."</i> This is a speculative conclusion without clear clinical sourcing, and is inappropriate to a 2567. Unless there is a documented clinical basis from an authoritative source, this language should be deleted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>During review of the chart, no order for the penicillin was found.</p> <p>The physician indicated she arrived at the facility at 9:00 a.m. on 3/17/16 and went straight to Resident B's room. She indicated he was listless on his bed and had breathing rapid at about 45 breaths per minute. His hands were cyanotic and cold. His heart rate was between 135-145 beats per minute. She indicated she could tell from the doorway that he was acutely ill. She told the staff to send him to the hospital. She indicated the staff was going to call the local fire department for transfer, but she insisted it was an emergency and to call 911. She indicated "there was no sense of urgency from staff." She indicated she had her phone on her 24 hours per day and staff could also call her nurse. She indicated she often received faxes at her home, but would leave early and get home late. She was also not wakened by a fax, but would never sleep through a phone call.</p> <p>During an interview on 3/31/16 at 12:13 p.m., LPN #3 indicated she was told by the DON to "not write the order for the penicillin" because the resident had already been transferred. She indicated she did receive the order from the physician's nurse. She indicated when</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>the blood cultures were ordered, there was no one in the facility that could draw the blood and the facility did not have the supplies to draw a blood culture.</p> <p>During an interview on 3/31/16 at 1:06 p.m., the DON indicated she did talk to the physician on Thursday. The DON indicated the facility did not have the supplies to draw the blood culture at that time and she was the only person who could draw the cultures. The DON indicated she spoke to the physician because she was concerned that she, herself, may need prophylactic antibiotics. She indicated the physician did seem surprised to hear the culture grew strep A.</p> <p>Review of a fax confirmation dated 3/14/16 at 1:04 a.m., provided by the DON on 3/31/16 at 2:51 p.m., indicated LPN #5 faxed the elevated temperature at 1:04 a.m. 7 hours after the noted temperature of 103.8 F.</p> <p>During an interview on 3/31/16 at 2:52 p.m., LPN #5 indicated the resident did have a temperature over 103.0 degrees F. She indicated she created the Situation Background Assessment Recommendation (SBAR) on 3/14/16 at 12:46 a.m. She indicated she faxed the SBAR to the physician, but did not hear</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>back from her. She indicated she told the charge nurse, but could not remember who it was. She indicated she did not find any additional attempts to contact the physician.</p> <p>She indicated Resident B had been coughing the previous day and that everyone had been sick. She stated she monitored his vital signs throughout the night, but did not document any of them. She indicated the fax number she sent the report to was listed as the physicians' home fax machine. She indicated she was unaware of the time frame for calling physicians' or vital sign parameters.</p> <p>Review of the Subject, Objective, Assessment and Plan (SOAP) note, dated 3/17/16 at 8:55 a.m., the physician indicated "positive for group A strep. PCN [penicillin] G 2m units IV q4h was ordered as soon as possible. When [name of resident] was seen this morning, he appeared acutely ill. He was tachypneic and tachycardic.</p> <p>Review of a current facility policy, dated 9/10/13 and titled "Notification of Change" provided by the DON on 3/29/16 at 8:50 a.m., indicated the following:</p> <p>"Purpose: Communicate to the resident,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>physician and resident's legal representative or interested family member when a change in condition occurs.</p> <p>Notification occurs when: An accident....</p> <p>A significant change in the residents physical mental or psychosocial status (i.e. deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications)</p> <p>A need to alter treatment....</p> <p>A decision to transfer....</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Assess resident's change in condition.... 2. Notify physician of condition change. ...5. Follow up nursing assessments continues until condition has stabilized. <p>An Immediate Jeopardy was identified on 3/31/16 at 12:00 p.m. The IJ began on 3/31/16 when the facility failed to provide timely communication related abnormal vital signs to the physician. The Immediate Jeopardy was removed on 4/1/16 when the facility implemented a plan of action to correct the deficiency. The corrective action included the following:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>"1. The physician must be immediately notified of any significant change in the resident's physical, mental, or psychosocial status.</p> <p>2. An SBAR will be thoroughly completed which will include the detailed information communicated to the physician including vital signs, mental status, functional status, respiratory status, GI/abdominal status, labs, etc.</p> <p>3. All attempts to notify the physician will be documented in the medical record.</p> <p>4. The physician will be contacted via telephone using the facility phone. No communication regarding orders or changes of condition will take place with the physician via fax, email or text messaging.</p> <p>In the event the nurse is unable to reach the physician in a timely manner, the Executive Director and Director of Nursing/designee with be contacted."</p> <p>During an interview on 4/1/16 at 10:12 a.m., the Administrator indicated the DON had updated all nursing staff on notification of change and only contacting the physician directly by telephone. She indicated the numbers had been posted at the nursing station and each person had to sign the form indicating they understood the change.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 0224 SS=J Bldg. 00	<p>She indicated the DON started inservicing the nursing staff shortly after noon on 3/31/16. She indicated the DON provided each nurse with a policy to notify the physician of any change. Each staff person was to date and sign the form. The nursing staff was also provided with the facility policy for "Notification of Change."</p> <p>Nursing staff on duty were interviewed on 4/1/16 to confirm each understood the changes in the policy. Staff interviewed included LPN# 11, LPN # 10, RN # 9, RN # 4, LPN # 7, and RN #8. Each staff person was aware of the inservice and changes made to machine compliance.</p> <p>This Federal tag relates to Complaint IN00196359. 3.1-5(a)(2)</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>property. Based on interview and record review, the facility failed to ensure the physician was notified in a timely manner of a resident's increased body temperature. This failure resulted in a delay in medical care, hospitalization and death (Resident B).</p> <p>The immediate jeopardy began on 3/13/16 when the facility failed to notify the physician of an elevated temperature of 103.9 degrees Fahrenheit (F). The Executive Director, Director of Nursing and Regional Director were notified of the immediate jeopardy on 3/31/16 at 12:00 p.m. The Immediate Jeopardy was removed 4/1/16 when the facility developed and implemented a systematic plan of correction.</p> <p>Findings include:</p> <p>During record review on 3/29/16 at 9:55 a.m., the clinical record indicated Resident B was admitted to the facility on 10/27/12. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, profound intellectual disability, anxiety, shaken infant syndrome and gasterostomy tube. The Minimum Data Set (MDS) quarterly assessment dated 1/7/16, indicated Resident B was unable to complete the</p>		F 0224	<p>F224J Prohibit Mistreatment/Neglect Corrective action for affected residents: Resident B discharged Identification of others at risk: Interviewable residents were interviewed and non-interviewable residents were assessed for any signs of abuse or neglect. No concerns were identified. Measures to ensure this deficit practice does not recur: License nurses were educated to the Abuse & Neglect Policy and Procedure. Monitoring of corrective action: Residents with significant changes in condition will be reviewed for signs of abuse or neglect 5 times weekly for 6 months, then 2 times weekly for 6 months. Results of this monitoring will be reported through the QA Committee for further recommendations. Plan of Compliance is effective: April 18, 2016 Vernon Manor requests changes in two deficiencies alleged in the 2567 for the survey completed April 1, 2016: we request a reduction in the scope and severity of finding F157 and the removal of finding F224 Mistreatment, Neglected Misappropriation. All findings associated with these tags relate to the same individual, Resident B. Please see attached IDR request Resident B was admitted</p>		04/18/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Brief Interview Mental Status (BIMS). Resident B was severely cognitively impaired.</p> <p>During review of a progress note dated 3/13/16 at 6:45 p.m., RN #1 noted a fever. The note indicated the nurse gave 600 milligrams of ibuprofen. On 3/14/16 at 6:00 a.m., LPN #2 indicated the resident was resting in bed, moaning. He had an elevated temperature and ibuprofen was given.</p> <p>Review of the vital signs record, on 3/13/16 at 6:04 p.m., Resident B had an elevated temperature of 103.9 degrees Fahrenheit (F).</p> <p>A progress note dated 3/14/16 at 11:57 a.m., LPN #2 indicated an elevated temperature and "tylenol" given.</p> <p>A progress note on 3/14/16 at 4:16 p.m., LPN #2 indicated an elevated temperature of 100 degrees F.</p> <p>A progress note dated 3/14/16 at 5:03 p.m., indicated LPN #2 notified "Md of increase temps." The physician responded to monitor the resident at this time.</p> <p>A progress note dated 3/14/16 at 7:00 p.m., RN #1 indicated an elevated</p>				<p>Vernon Manor on 10/27/2012. His diagnoses included spastic quadriplegic cerebral palsy, profound intellectual disability, anxiety, shaken infant syndrome, gastrostomy tube, autistic disorder and severe cognition impairment.</p> <p>On the evening of Sunday, March 13, 2016, the attending nurse identified that Resident B felt warm and had a temperature of 103.9. After administering ibuprofen, she attempted to contact the attending physician by phone. The physician did not answer. The physician does not have voicemail set up and the nurse was unable to leave a message. She subsequently completed a SBAR (Subject Background Assessment Request) and faxed it to the physician (Exhibit A.) The facility received confirmation that the fax was received (Exhibit B.). Vernon Manor received no response.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>temperature of 102.5 F. Ibuprofen was given. RN #1 noted the abdomen to be "slightly firm and tender to palpation, resident is expelling gas."</p> <p>A note dated 3/14/16 at 8:02 p.m., RN #1 indicated an elevated temperature of 100.2 F, but indicated the resident continued to have abdominal tenderness with palpation.</p> <p>A progress note dated 3/15/16 at 12:52 p.m., indicated resident was afebrile (temperature not elevated) with hypoactive bowel sounds and discomfort with palpation.</p> <p>A progress note dated 3/15/16 at 1:29 p.m., indicated the physician was notified of the residents vital signs and abdominal tenderness. No specific numbers were indicated.</p> <p>A progress note dated 3/15/16 at 2:49 p.m., RN #4 indicated a new order for Resident B to have the following: "chest x-ray, Complete Blood Count (CBC), Basic Metabolic Panel (BMP) and 2 sets of blood cultures done 15 minutes apart." The order indicated the chest x-ray would be done "tonight."</p> <p>A progress note dated 3/15/16 at 5:00 p.m., LPN #3 indicated "may have labs</p>				<p>The next morning, at 9:57 a.m. a Vernon Manor nurse notified the physician's nurse that Resident B had elevated temperatures. Approximately two hours later Vernon Manor received an order to monitor the resident (Exhibit C and D.) Neither a discontinuation of an existing form of treatment nor a commencement of a new form of treatment was ordered at that time.</p> <p>The principal focus of tag F 157 seems to be the performance of the staff after Resident B was noted as having a high temperature on March 13. Vernon Manor contends that it used reasonable efforts to advise and consult with Resident B's physician concerning the change in Resident B's temperature on March 13. Shortly after the increased temperature was noted, a call was placed to the physician. The physician did not answer. The physician acknowledges</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>drawn 3/16/16 in the AM per [name of physician].</p> <p>A progress note dated 3/16/16 at 1:58 a.m., LPN #5 indicated the breath sounds had rhonchi [low-pitched] breath sounds.</p> <p>A progress note dated 3/16/16 at 8:30 a.m., indicated "CBC, BMP and blood cultures drawn per hosp lab from left hand this am. 15 minutes later 2nd set of blood cultures drawn from right hand."</p> <p>A note dated 3/16/16 at 12:27 p.m., indicated the Director of Nursing (DON) informed the physician of the chest x-ray results. The x-ray indicated a right perihilar infiltrate. The physician was also notified of the CBC and BMP results.</p> <p>A new order was received on 3/16/16 at 3:48 p.m. The order indicated to start Bactrim DS [antibiotic] 800mg/160mg, 1 tablet twice daily for 10 days and Zithromax [antibiotic] 500 mg daily for 10 days. The family was notified of the order.</p> <p>A progress note dated 3/17/16 at 2:06 a.m., LPN #5 indicated "Dr. [name of physician] notified of culture results." Review of laboratory blood culture results, dated 3/16/16, indicated a</p>		<p>that she does not have voice mail set up. Nursing measures were implemented, including monitoring of vital signs each shift. As the preferred method of contacting the physician had not worked, the nurse followed up with a fax to the physician advising of the change. The surveyor's criticism of the Vernon Manor nurse for not doing additional follow-up is unwarranted, as Vernon Manor received verification that the fax had been received.</p> <p>We also note inconsistencies in the survey. Page 15 includes statement from the physician that she received no updates on Resident B's condition on March 16. In fact, the physician's nurse was present in Vernon Manor on that day and observed Resident B. In addition, it is noted on page 5 that the DON informed the physician of the CBC and BMP results.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>preliminary result of Streptococcus A. Interview with LPN #5 indicated she had faxed the report and not actually spoken to the doctor.</p> <p>A progress note dated 3/17/16 at 7:30 a.m., indicated the DON spoke to the physician about the positive blood culture, related to isolation precautions.</p> <p>A note on 3/17/16 at 8:40 a.m., indicated Resident B was observed between the floor and the bed, "crawling as per normal...." Resident B was observed to have the following abrasions: 4.5 cm x 5.0 cm to the right temple and a 2 cm x 2 cm to right ankle. Emesis was on his clothing and bedding. LPN #3 indicated "BrSo [breath sounds] are clear and BoSo [bowel sounds] active in all four quadrants".</p> <p>At 9:00 a.m., the physician was notified in person of the resident's vital signs and went to assess the resident. The order was given to send the resident to the local hospital. Resident B was transported to the hospital on 3/17/16 at 9:15 a.m.</p> <p>Review of an Event Report, dated 3/13/16 at 6:45 p.m., LPN #5 noted a temperature of 103.8 degrees F. The report indicated the event started on 3/13/16 at 6:03 p.m. The report indicated</p>		<p>In addition, communication with the physician regarding Resident B's temperatures and general status continued on March 15 at 1:29 p.m. (Exhibit E), March 15 at 2:49 p.m. (Exhibit F), March 15 at 5:00 p.m. (Exhibit G), March 16 at 12:27 p.m. (Exhibit H), March 16 at 3:48 p.m. (Exhibit I), March 17 at 2:06 a.m. (Exhibit J), March 17 at 5:10 a.m. (Exhibit K), March 17 at 7:30 a.m. (Exhibit L) and March 17 at 9:00 a.m. (Exhibit M). Resident B was evaluated by the physician on the morning of March 17 and subsequently transferred to a hospital.</p> <p>Attached as Exhibit N is a chronology showing communications and significant events involving Resident B over the period in question. The events identified in 2567 are shaded. Exhibit N shows that there were more communications between Vernon Manors' nursing staff, the physician, and the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>"Physician Notified: Yes Date/Time: 3/14/16 at 12:51 AM".</p> <p>During an interview on 3/31/16 at 9:20 a.m., the physician indicated she was not notified of an elevated temperature of 103.9. She indicated she was notified of a temperature on Monday from her nurse. The physician's nurse, LPN #6, indicated she had received a text message from LPN #2 on 3/14/16 at 9:57 a.m., indicating Resident B had a temperature in the 100 range and had vomited his narcotic medication. The physician indicated she was informed on Tuesday (3/15/16) the resident had abdominal tenderness, but with positive bowel sounds. She received no update on Wednesday(3/16/16). She indicated on Thursday (3/17/16), she had received a fax at 2:35 a.m., indicating a positive blood culture. The report only indicated the resident had Gram Positive Cocci (GPC). She indicated she had spoken to the DON prior to her 8:00 a.m. meeting. She indicated the DON was concerned about the blood culture containing streptococcus pyogenes (strep A). The physician indicated she was not aware of the recent culture results. She indicated she immediately contacted her nurse and gave an order for Penicillin 2 million units intravenously every 4 hours with no stop date. She indicated she gave that</p>		<p>physician's nurse than reflected in the 2567. Several of these additional communications are set forth in Exhibit O.</p> <p>Tag F 224 asserts that Vernon Manor violated regulation 42 CFR 483.13(c), and the same observations used to support F 157 are used to support F 224. We make the same responses to F 224 as to F 157.</p> <p>We furthermore dispute the conclusion on page 11 that <i>"...the facility failed to ensure the physician was notified in a timely manner of a resident's increased body temperature. This failure resulted in a delay in medical care, hospitalization and death."</i> This is a speculative conclusion without clear clinical sourcing, and is inappropriate to a 2567. Unless there is a documented clinical basis from an authoritative source, this language should be deleted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>order around 7:55 a.m., just before her meeting started.</p> <p>During an interview on 3/31/16 at 9:20 a.m., LPN #6 indicated she wrote the order on a sticky note and gave to LPN #3. The note indicated an order for Penicillin 2 million units intravenously every 4 hours with no stop date</p> <p>During review of the chart, no order for the penicillin was found.</p> <p>The physician indicated she arrived at the facility at 9:00 a.m. on 3/17/16 and went straight to Resident B's room. She indicated he was listless on his bed and had breathing rapid at about 45 breaths per minute. His hands were cyanotic and cold. His heart rate was between 135-145 beats per minute. She indicated she could tell from the doorway that he was acutely ill. She told the staff to send him to the hospital. She indicated the staff was going to call the local fire department for transfer, but she insisted it was an emergency and to call 911. She indicated "there was no sense of urgency from staff." She indicated she had her phone on her 24 hours per day and staff could also call her nurse. She indicated she often received faxes at her home, but would leave early and get home late. She was also not wakened by a fax, but would</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>never sleep through a phone call.</p> <p>During an interview on 3/31/16 at 12:13 p.m., LPN #3 indicated she was told by the DON to "not write the order for the penicillin" because the resident had already been transferred. She indicated she did receive the order from the physician's nurse. She indicated when the blood cultures were ordered, there was no one in the facility that could draw the blood and the facility did not have the supplies to draw a blood culture.</p> <p>During an interview on 3/31/16 at 1:06 p.m., the DON indicated she did talk to the physician on Thursday. The DON indicated the facility did not have the supplies to draw the blood culture at that time and she was the only person who could draw the cultures. The DON indicated she spoke to the physician because she was concerned that she, herself, may need prophylactic antibiotics. She indicated the physician did seem surprised to hear the culture grew strep A.</p> <p>Review of a fax confirmation dated 3/14/16 at 1:04 a.m., provided by the DON on 3/31/16 at 2:51 p.m., indicated LPN #5 faxed the elevated temperature at 1:04 a.m. 7 hours after the noted temperature of 103.8 F.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>During an interview on 3/31/16 at 2:52 p.m., LPN #5 indicated the resident did have a temperature over 103.0 degrees F. She indicated she created the Situation Background Assessment Recommendation (SBAR) on 3/14/16 at 12:46 a.m. She indicated she faxed the SBAR to the physician, but did not hear back from her. She indicated she told the charge nurse, but could not remember who it was. She indicated she did not find any additional attempts to contact the physician.</p> <p>She indicated Resident B had been coughing the previous day and that everyone had been sick. She stated she monitored his vital signs throughout the night, but did not document any of them. She indicated the fax number she sent the report to was listed as the physicians' home fax machine. She indicated she was unaware of the time frame for calling physicians' or vital sign parameters.</p> <p>Review of the Subject, Objective, Assessment and Plan (SOAP) note, dated 3/17/16 at 8:55 a.m., the physician indicated "positive for group A strep. PCN [penicillin] G 2m units IV q4h was ordered as soon as possible. When [name of resident] was seen this morning, he appeared acutely ill. He was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>tachypneic and tachycardic.</p> <p>Review of a current facility policy, dated 8/8/13 and titled "ABUSE, NEGLECT, AND MISAPPROPRIATION OF PROPERTY" provided by the DON on 3/29/16 at 8:50 a.m., indicated the following: "Purpose: Prevent abuse, neglect and misappropriation of property. Procedure: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property of residents. ...Training: ...3. Staff members will identify and assess... ...E. Neglect, the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. ...Protection: 1. All residents will be protected from harm.</p> <p>Review of another facility policy, dated 9/10/13 and titled "Notification of Change" provided by the DON on 3/29/16 at 8:50 a.m., indicated the following: "Purpose: Communicate to the resident, physician and resident's legal representative or interested family</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>member when a change in condition occurs.</p> <p>Notification occurs when: An accident....</p> <p>A significant change in the residents physical mental or psychosocial status (i.e. deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications)</p> <p>A need to alter treatment....</p> <p>A decision to transfer....</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Assess resident's change in condition.... 2. Notify physician of condition change. ...5. Follow up nursing assessments continues until condition has stabilized. <p>An Immediate Jeopardy was identified on 3/31/16 at 12:00 p.m. The IJ began on 3/31/16 when the facility failed to provide timely communication related abnormal vital signs to the physician. The Immediate Jeopardy was removed on 4/1/16 when the facility implemented a plan of action to correct the deficiency. The corrective action included the following:</p> <p>"1. The physician must be immediately notified of any significant change in the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>resident's physical, mental, or psychosocial status.</p> <p>2. An SBAR will be thoroughly completed which will include the detailed information communicated to the physician including vital signs, mental status, functional status, respiratory status, GI/abdominal status, labs, etc.</p> <p>3. All attempts to notify the physician will be documented in the medical record.</p> <p>4. The physician will be contacted via telephone using the facility phone. No communication regarding orders or changes of condition will take place with the physician via fax, email or text messaging.</p> <p>In the event the nurse is unable to reach the physician in a timely manner, the Executive Director and Director of Nursing/designee will be contacted."</p> <p>During an interview on 4/1/16 at 10:12 a.m., the Administrator indicated the DON had updated all nursing staff on notification of change and only contacting the physician directly by telephone. She indicated the numbers have been posted at each person had to sign the form indicating they understood the change. She indicated the DON started inservicing the nursing staff shortly after noon on 3/31/16. She</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/01/2016	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>indicated the DON provided each nurse with a policy to notify the physician of any change. Each staff person was to date and sign the form. The nursing staff was also provided with the facility policy for "Notification of Change."</p> <p>Nursing staff on duty were interviewed on 4/1/16 to confirm each understood the changes in the policy. Staff interviewed included LPN# 11, LPN # 10, RN # 9, RN # 4, LPN # 7, and RN #8. Each staff person was aware of the inservice and changes made to machine compliance.</p> <p>This Federal tag relates to Complaint IN00196359.</p> <p>3.1-28(a)</p>						